CHANGE OF ADDRESS FORM

I request that my address be changed to the following:

_____

Address

_____

City, State, Zip

_____ _____

Home Phone Cell Phone

_____

Employee (Print Name)

_____

Employee (Signature)

_____

Date

NORTH CAROLINA 401(k) SUPPLEMENTAL RETIREMENT PLAN

Request for Name and/or Address Change

NC 401(k) PLAN

Instructions **Please print using blue or black ink.** Send completed form to the following address or fax it to **1-866-439-8602**. If faxing, please keep original for your records.

NC Plans Processing Center
PO Box 5340
Scranton, PA 18505

Questions?
Call 1-866-627-5267
for assistance.

About You

Plan number: 0 0 2 0 0 3

Sub plan number:

Email address: _____

Social Security number: ___-___-____

Daytime telephone number: ___-___-____ *area code*

First name | MI | Last name

Name Change

My name has been changed to the following:

First name | MI | Last name

Reason: _____
example: marriage, divorce, court order, reported incorrectly, misspelled, etc.

We must receive one of the following documents to make a name change:

- Copy of the marriage certificate
- Copy of a court order or judgment indicating the name change
- Copy of Social Security card

New Address

New address

City | State | ZIP code

Daytime telephone number

___-___-____
area code

Your Authorization

I understand that Prudential will rely on the information I have provided in processing this request. I further understand that I am responsible for its accuracy in the event any dispute arises.

X _____ *Participant's signature* *Date* ___/___/___

Ed. 4/2010

Prudential Retirement

Group Change Card

MedCost BENEFIT SERVICES
d/b/a MBS Third Party Administrators in California

Health Benefits Trust

1. Employer _____ **2.** Organization ID #90 _____

SECTION I **PERSONAL DATA**

3. Employee Name (LAST, FIRST, MI) _____ **4.** Social Security # _____

5. Date Of Birth _____

SECTION II **ADDITIONS OF COVERAGE (check all that apply)**

6. Indicate desired additions to current coverages below:

DENTAL	BASIC LIFE	MEDICAL	VISION	SHORT-TERM DISABILITY	LONG-TERM DISABILTY	SUPPLEMENTAL LIFE*
☐ EMPLOYEE	☐ EMPLOYEE	☐ EMPLOYEE	☐ EMPLOYEE	☐ YES	☐ YES	AMOUNT $ _____
☐ SPOUSE	☐ DEPENDENT	☐ SPOUSE	☐ SPOUSE	☐ NO	☐ NO	☐ DECLINE
☐ CHILD(REN)		☐ CHILD(REN)	☐ CHILD(REN)			

List any covered dependents that will be affected by this change *(attach additional pages if necessary):*
Certificate of Dependent Eligibility form for dependents with last names different than the employee must be attached to this enrollment card.

	SSN	LAST NAME	FIRST NAME	MI	SEX	DATE OF BIRTH	DISABLED*
SPOUSE							
CHILD							
CHILD							
CHILD							

**If child is disabled and over age 26, please submit proof of disability.*

Do you or your newly added dependents have previous creditable medical coverage under another health plan such as an employer sponsored group health plan or HMO, individual policy, Medicare, Medicaid or Champus? ☐ YES ☐ NO

If yes, a copy of any certificates may be required prior to any claims being processed under this plan. ☐ CERTIFICATED ATTACHED ☐ CERTIFICATE BEING FORWARDED

7. Current annual salary _____ **8.** Effective date of change _____

9. Reason for addition of coverage ☐ MARRIAGE (DATE_____) ☐ OTHER _____(YOU MUST SPECIFY REASON IF OTHER)
☐ BIRTH ☐ LOSS OF OTHER COVERAGE (DATE OF COVERAGE LOSS _____)

SECTION III **TERMINATIONS OF COVERAGE**

10. Indicate desired terminations of current coverages below:

DENTAL	BASIC LIFE	MEDICAL	VISION	SHORT-TERM DISABILITY	LONG-TERM DISABILITY	SUPPLEMENTAL LIFE*
☐ EMPLOYEE	☐ EMPLOYEE	☐ EMPLOYEE	☐ EMPLOYEE	☐	☐	☐
☐ SPOUSE	☐ DEPENDENT	☐ SPOUSE	☐ SPOUSE			
☐ CHILD(REN)		☐ CHILD(REN)	☐ CHILD(REN)			

List any covered dependents that will be affected by this change *(attach additional pages if necessary):*

	SSN	LAST NAME	FIRST NAME	MI	SEX	DATE OF BIRTH
SPOUSE						
CHILD						
CHILD						
CHILD						

11. Employee's last date of employment: _____ **12.** Effective date of termination: _____
Coverage terminates at 12:00 p.m. (midnight) on last date of employment. COBRA information will be mailed to participant's last known address. If address has changed, please indicate on back of change card.

13. Reason for termination of coverage: ☐ TERMINATION OF EMPLOYMENT ☐ RETIRING BENEFITS ☐ DEATH ☐ DIVORCE/SEPARATION (DATE: _____)
☐ TURNED 19 AND NOT A STUDENT ☐ WORKING LESS THAN 20 HOURS PER WEEK
☐ OTHER _____ (YOU MUST SPECIFY REASON IF OTHER)

NC LEAGUE OF MUNICIPALITIES
RISK MANAGEMENT SERVICES

OVER

SECTION IV **CHANGES IN COVERAGE STATUS**

15. Indicate desired changes to current coverages below:

BASIC LIFE
- ☐ EMPLOYEE

CHANGES IN ACTIVE EMPLOYEE STATUS TO
- ☐ GENERAL EMPLOYEE
- ☐ DEPARTMENT HEAD
- ☐ TOP ADMINISTRATOR

CHANGES FROM CURRENT STATUS TO

RETIREE
- ☐ EMPLOYEE
- ☐ SPOUSE
- ☐ CHILD(REN)

MEDICARE SUPPLEMENT*
- ☐ EMPLOYEE
- ☐ SPOUSE

**Copy of Medicare card required to change status to Medicare Supplement.*
If retiring with partial benefits, indicate coverages terminated on front of change card.

Employee current annual salary _____ **16.** Effective date of change _____

Department change ☐ YES ☐ NO Name of new department _____

SECTION V **NAME, ADDRESS, BENEFICIARY CHANGES**

17. Change employee's name: FROM: _____

TO: _____

18. Change employee's address TO: _____

_____

19. Change beneficiary TO: _____ RELATIONSHIP _____ BIRTHDATE _____

NDICATE FULL NAME OF BENEFICIARY, I.E., MARY E. DOE, MRS. JOHN DOE

_____

☐ By this request I revoke all prior beneficiary designations.

20. Change supplemental life beneficiary TO: _____ RELATIONSHIP _____ BIRTHDATE _____

INDICATE FULL NAME OF BENEFICIARY, I.E., MARY E. DOE, MRS. JOHN DOE

☐ By this request I revoke all prior beneficiary designations.

21. Employee Signature _____ **22.** Date _____

Employee's signature is required for all changes and terminations except termination of employment.

MUST BE COMPLETED BY THE EMPLOYER IN ORDER TO BE PROCESSED

I certify the above information to be complete and accurate to the best of my knowledge

23. Authorized Signature: _____ **24.** Date _____

Call MedCost at 1-800-795-1023 if you have any questions.

MAIL CHANGE CARD IMMEDIATELY WITH APPROPRIATE DOCUMENTATION TO: MedCost Benefit Services
Post Office Box 24042
Winston-Salem, North Carolina 27114-4042

Enrollment/Change Application

Instructions:

- All employees complete Sections **A**, **C**, **D**, **E**, **G** and **H**.
- For change requests, complete Sections **A**, **B** and all other applicable sections.
- If your group has elected USAble Life products you must complete Section **F**. **For USAble®1 Life Only** you must complete Sections **A**, **B**, **F**, **G** and **H**.

Completed by Group Administrator Only
Group Number (if applicable):
Life Class Designation (if applicable):

Please type or print in black or blue, NOT RED ink

A. Employee information

First Name	Middle Initial	Last Name	Suffix

Employee Birthdate (mm dd yyyy)	Employee Social Security Number	☐ Male ☐ Female	Marital Status

Address	P.O. Box (For Blue Options HSA you must also provide a street address.)	Apt. No.	City	State	Zip Code

Company Name	Occupation

Work Location	Date of Full Time Employment (mm dd yyyy)	Language Preference
		☐ Spanish ☐ English ☐ Other _____

Home Phone Number	Work Phone Number	E-Mail Address
( )	( )	

Ethnicity: (This information is optional and will not be used in a discriminatory manner. Responses or nonresponses to this question will not affect eligibility for coverage.)

☐ African American/Black ☐ Asian/Asian American ☐ Choose not to report
☐ White/Caucasian ☐ Hispanic/Latino ☐ Native American/Alaskan Native ☐ Other (specify) _____

☐ ACTIVE EMPLOYEE ☐ COBRA/STATE CONTINUATION

COBRA/State Continuation Qualifying Event: ☐ Termination of Employment ☐ Reduction in Hours ☐ Death of Subscriber ☐ Divorce ☐ Over Age Dependent ☐ Medicare Eligible

What was the date of the Qualifying Event? (mm dd yyyy) Date Continuation Started (mm dd yyyy) Date Continuation Ends (mm dd yyyy)

B. If making a change from previous enrollment

Check All That Apply:

- ☐ Name
- ☒ Address
- ☐ Other Insurance Information
- ☐ Telephone
- ☐ Replace ID Card
- ☐ Date of Birth Correction
- ☐ E-Mail Address
- ☐ Late Applicant
- ☐ Over the Guarantee Issue
- ☐ Other _____

Add Dependent(s): Date of Occurrence (mm dd yyyy)

- ☐ Marriage
- ☐ Newborn
- ☐ Adoption
- ☐ Other _____

Remove Dependent(s): Date of Occurrence (mm dd yyyy)

- ☐ Divorce
- ☐ Dependent Age
- ☐ Death
- ☐ Other _____

Reinstate Coverage:

Reason: _____

Cancel Coverage: Date of Occurrence (mm dd yyyy)

- ☐ Not Eligible
- Reason: _____
- ☐ Left Employment
- ☐ Subscriber Request
- ☐ Other
- Reason: _____

Employee Name:

H. Statement of authorization for release of protected health information - your signature is required

I understand that if I refuse to sign this authorization that BCBSNC and/or USAble Life may refuse to enroll me or determine that I am not eligible for benefits in BCBSNC and/or USAble Life.

I understand that my protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, or a health care clearinghouse and that relates to:

(i) my past, present, or future physical or mental health or condition;

(ii) the provision of health care to me; or

(iii) the past, present, or future payment for the provision of health care to me.

I authorize any current or past medical professional, medical care institution or other medical care giver that has treated me or provided medical services or supplies to me to disclose my protected health information to BCBSNC and/or USAble Life.

I further authorize BCBSNC and/or USAble Life to review any applications for health care coverage that I may have submitted to BCBSNC and/or USAble Life in the past.

I authorize BCBSNC and/or USAble Life to receive, use and disclose as necessary my protected health information in connection with any underwriting or eligibility determination purposes in connection with the coverage for which I have applied.

The protected health information (excluding psychotherapy notes) that may be used and disclosed is as follows:
Medical records or any information concerning my current or past health status or treatment received from my medical care providers or previous applications for health care coverage.

I understand that BCBSNC and/or USAble Life will use my protected health information for the following purposes:
To determine my eligibility for enrollment and my premium rate.

I understand that BCBSNC and/or USAble Life will make every effort to safeguard my protected health information. I further understand that BCBSNC and/or USAble Life will not disclose my protected health information unless I request it or when state or federal privacy laws permit or require BCBSNC and/or USAble Life to disclose my protected health information. I understand that BCBSNC and/or USAble Life may disclose my protected health information to individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations. I understand that if my protected health information is received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by the federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by sending a written notification addressed to:

Rating
Blue Cross and Blue Shield of North Carolina
P.O. Box 30013
Durham, NC 27702

USAble Life
320 West Capital Avenue
Suite 700
Little Rock, Arkansas 72201

and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective:

(i) for information that BCBSNC and/or USAble Life already used or disclosed, relying on this authorization or

(ii) if the authorization was obtained as a condition of coverage in BCBSNC and/or USAble Life and, by law, BCBSNC and/or USAble Life has a right to contest the coverage.

This authorization expires 120 days from the date this authorization is signed by the applicable person listed below. After 120 days expire, BCBSNC and/or USAble Life may no longer use this information.

Signature of Primary Applicant or Legal Personal Representative: X _____ Date mm dd yyyy

Name of Legal Personal Representative and Relationship to Primary Applicant (please print): _____ Date mm dd yyyy